DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

IN REPLY REFER TO
BUMEDINST 6150.38
BUMED-M3M12
29 Jul 2003

BUMED INSTRUCTION 6150.38

From: Chief, Bureau of Medicine and Surgery

Subj: OUTPATIENT CODING STANDARD BUSINESS PRACTICES, PROCESSES, AND REPORTING REQUIREMENTS

Ref: (a) Health Insurance Portability and Accountability Act (HIPAA) of 1996, (P.L. 104-91)
(b) Professional Services and Outpatient Coding Guidelines (http://www.tricare.osd.mil/org/pae/ubu/downloads/ADS_Coding_Guidelines_final_1-Oct-2002.doc)
(c) NAVMED P-117, Manual of the Medical Department, Chapter 16 (http://www.vnh.org/Admin/MMD/MMDChapter16.pdf)
(d) The Office of Inspector General's Compliance Program Guidance for Hospitals, February 1998 (http://www.ahima.org/infocenter/models/oig.pdf)
(e) TMA Compliance Audit Checklist (http://www.tricare.osd.mil/ebc/rm_home/files/ubo/ubo_compliance_binder_audit_tool.doc)
(f) BUMED Patient Administration Web site (https://bumed.med.navy.mil/pad/)
(g) BUMED Data Quality Web site (http://navymedicine.med.navy.mil/M8/financial/dataquality.cfm)
(h) BUMEDINST 5450.156B (http://navymedicine.med.navy.mil/instructions/external/5450-156B.pdf)
(i) BUMEDINST 6010.17B (http://navymedicine/instructions/external/6010.17b.pdf)

Encl: (1) Clinical Records Management Plan
(2) Outpatient Coding Protocol Plan
(3) Health Care Support Office Superbill Development List
(4) Best Practices for Ambulatory and Outpatient Clinics
(5) Financial Reporting Requirements

1. Purpose. To designate roles and responsibilities in outpatient coding and standardize coding practices, processes and reporting requirements, to include associated financial reporting requirements. This instruction requires a mandatory audit process, a closed medical record system and the separation of functions associated with billing and coding. References (a) through (i) and enclosures (1) through (5) will be used by military treatment facilities (MTFs) to establish management controls that support patient care, management of medical records, reporting responsibilities, sustaining accurate health information data and financial reporting.

2. Background. Appropriate, accurate, and timely documentation of patient care encounters is an essential component of efficient patient care. An integral component of this documentation process is coding; the description of the care we have rendered, translated into current procedural terminology (CPT), and other universally applied health care industry nomenclatures. The result

of the coding process is data that drives operations, serves as critical elements in population health programs, as the necessary language enabling reimbursement by payors, and as the critical cornerstones impacting every decision regarding MTF operations through our management information and data systems. Implementation of the collection from third party payors of reasonable charges for health care services and changes mandated by reference (a) and TRICARE for Life legislation requires extensive MTF and headquarters outpatient change management actions. These changes must occur to meet the same high standards of integrity, compliance, and accuracy regarding health care data that is required of our civilian counterparts. MTFs can expect to be subjected to the same level of scrutiny of business practices and processes that apply to the civilian health care industry and should expect the same sanctions levied when discrepancies are found.

3. Discussion. Outpatient coding is crucial to Office of the Assistant Secretary of Defense, Health Affairs (OASD(HA)) programs such as third party reimbursement, itemized billing, the Data Quality Program and HIPAA implementation. As indicated in reference (b), accurate capture of outpatient data that clearly documents the outpatient health care services provided by the MTF is essential. In addition, outpatient coding is important to the MTF's ability to manage issues related to population health and financial reimbursement from third party payors. The importance of full compliance with outpatient coding standards cannot be overstated. Significant penalties for fraudulent coding and billing practices exist even if the error is unintentional. MTF focus on the auditing of outpatient codes and medical records is vital and will lead to significant improvements in clinical documentation, health information, and cost recovery.

4. Policy. MTF managerial controls must be put into place to ensure standard business practices and processes outlined in the applicable enclosures are implemented. Head, patient administration department (PAD) (or equivalent) and the medical record administrator (MRA) are the personnel critical to ensure the requirements of this instruction and its enclosures are met.

a. Documentation of outpatient care will be accomplished at all Navy MTFs in a manner that ensures all patient care services rendered are accurately, completely, and efficiently recorded in both the outpatient medical record and the Standard Ambulatory Data Record (SADR). This can be accomplished only through enforcement of a closed medical record system as mandated by reference (c) and outlined in enclosure (1). Additionally, all encounters that may result in claims or bills requesting reimbursement for services must be accurate, complete, and timely. Therefore, an audit of 100 percent of Other Health Insurance (OHI) for the Third Party Outpatient Collections System (TPOCS)/Medical Services Account (MSA) and Medical Affirmative Claims Program (MACP) claims must be performed prior to being submitted to a third party payor. Reference (d) provides several options for consideration in accomplishing this requirement. Reference (e) lists established metrics, monitoring, auditing, and reporting requirements that are submitted via the Health Care Support Offices (HLTHCARE SUPPOs) monthly.

b. While this instruction focuses on some specific components of a compliance plan, it does not meet the complete spectrum of compliance as defined under reference (d). Reference (f) is included to assist MTFs in evaluating their outpatient coding programs. Additionally, reference (g)

states that the coding and billing functions must be distinctly separate. MTF commanding officers must ensure the functions are not performed by the same person or by personnel reporting to the same supervisor.

5. Scope. It is expected that each MTF will design processes that meet local needs and comply with the minimum standard business practices, processes, and reporting requirements included in this instruction. These processes include the oversight and audit of outpatient coding with specific attention to OHI for TPOCS/MSA and MACP claims, a closed medical record system, staff training to ensure that all the clinical and administrative requirements associated with an outpatient encounter are performed, and oversight of dollars, labor hours, and full-time equivalent (FTE) utilization in support of this policy.

6. Responsibilities. The following lists the roles and responsibilities of the Bureau of Medicine and Surgery, the HLTHCARE SUPPOs, and the MTFs.

a. Chief, BUMED

(1) BUMED, M3M12, Patient Administration and TRICARE Operations Branch, is responsible for development and oversight of policies concerning outpatient coding standard business practices, processes, and reporting requirements.

(2) BUMED MRA is responsible for closely monitoring the quality of health care information throughout Navy Medicine and provides expertise in DOD table and file updates. The MRA provides guidance and instruction to the HLTHCARE SUPPOs and MTFs on the functionality of any updates or changes to outpatient care documentation requirements, including International Classification of Diseases, Ninth Revision, Clinical Modifications (ICD-9-CM), CPT-4, and Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS Level II) diagnostic codes.

(3) Develops annual performance metrics and a tracking mechanism to monitor MTF compliance with coding and the closed medical record system.

b. HLTHCARE SUPPOs

(1) Are responsible for assisting BUMED with development of policies and procedures governing implementation and management of outpatient coding standard business practices, development of metrics, interpretation of data and results of metrics as indicated in reference (h).

(2) Will oversee and assist MTFs within their respective area of responsibility (AOR) in implementation of the policies and procedures defined in this instruction.

(3) HLTHCARE SUPPO MRAs are responsible for functional and technical MTF issues that cannot be resolved at the local level.

c. MTFs

(1) The MTF commanding officer has the ultimate responsibility to ensure that all clinical documentation, clinical coding, and administrative procedures surrounding patient encounters are conducted following the requirements of this instruction, applicable State and Federal laws, and the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) standards.

(2) The PAD is responsible to the commanding officer for ensuring compliance with this instruction and has functional oversight of the administrative coding processes supporting outpatient encounters. The PAD officer is also responsible for maintenance of a closed medical record process within the MTF's AOR and development of an annual Outpatient Coding Protocol Plan as outlined in enclosure (2). The purpose of the plan is to establish guidelines for daily business practices at all levels of responsibility, ensuring policies are effectively executed, to include the review of 100 percent of OHI claims for the TPOCS/MSA and MACP prior to filing with third party payors.

(3) The head, financial management department or appropriate counterpart is responsible to the commanding officer for efficient operation of the billing office, outpatient third party reimbursement itemized billing, and collection of reimbursables. These functions must remain separate from and independent of, the patient administration coding functions.

(4) The MRA reports to the head, PAD, or appropriate counterpart. The MRA is responsible for oversight of the outpatient coding staff, outpatient standard coding processes and practices including audits, and assisting with management of the closed medical records system. The MRA is further responsible for ensuring that clinical documentation in the patient record supports and justifies the coding assigned for the episode of care. Deficiencies must have corrective action taken when identified.

7. Action. The following programs and processes are to be implemented immediately:

a. BUMED

(1) Develop annual performance metrics and a tracking mechanism to monitor MTF compliance with coding and the closed medical record system.

(2) Review, approve, and disseminate all standard outpatient ambulatory data module (ADM) coding superbills.

(3) Ensure the Naval Medical Information Management Center (NMIMC) SPMS/EASE/ Help Desk (SEAHelp Desk) at (301) 319-1296, DSN 285-1296, or by e-mail at Seahelp@us.med. navy.mil is used to assist with technical as well as functional issues that may arise in implement-ing requirements within this instruction.

b. HLTHCARE SUPPOs

(1) Standardize ADM superbills by clinical specialty as listed in enclosure (3). Ensure superbills are coordinated and approved by appropriate Navy specialty leaders and other HLTHCARE SUPPOs before forwarding to BUMED-M3M12 for final approval and distribution to the MTFs.

(2) Assist BUMED in development of annual performance metrics and provide status reports and annual review of MTF outpatient coding performance to BUMED-M3M12.

(3) Assist MTFs in implementation of requirements associated with this instruction to include the closed medical record system, 100 percent review of OHI claims for TPOCS/MSA, and MACP prior to filing with third party payors.

(4) HLTHCARE SUPPO will ensure the NMIMC SEAHelp Desk is used to assist with technical as well as functional issues that may arise in implementing requirements within this instruction.

c. MTF

(1) Establish head, PAD or appropriate counterpart as responsible official for outpatient coding and record management activities to include management of the closed medical record system, documentation requirements, coding, and auditing processes.

(2) Establish procedures to review 100 percent of OHI MSA and DD7A claims prior to billing third party payors to include resolving discrepancies between clinical documentation and actual coding of the encounter via ADM or other information systems (e.g., Provider GUI).

(3) Train all personnel involved in record management activities including handling, storage and retrieval of physical records, and health care documentation, as stated in enclosure (1). Enclosure (4) provides examples to assist in establishment of business practices that support this effort.

(4) Comply with the metrics and reporting requirements as outlined in reference (e). Continue submission of monthly data quality statements and take corrective action when deficiencies are identified. In the interim, use guidance and standards provided by reference (f) to assist in evaluation of outpatient coding practices and process. In cases of repeated deficiencies or possible fraud by individuals, commanding officers are to investigate and take corrective action, including disciplinary action as appropriate.

(5) Implement financial reporting requirements, as outlined in enclosure (5), to support oversight of resources executed with regard to this instruction.

(6) Use the 1995 Centers for Medicare and Medicaid Services Documentation Guidelines for Evaluation and Management Services as the default E&M standard for operation of the outpatient coding program.

M. L. COWAN

Distribution:
MTF Commanders
HEALTHCARE SUPPO Commanders
TRICARE Lead Agent Region Two
TRICARE Lead Agent Region Nine
NMIMC
Internal BUMED Codes (M3M, M8, and M1)

Copy to:
Internal BUMED Code (M09BMSC)

Available at: http://navymedicine.med.navy.mil/instructions/directives/default.asp

CLINICAL RECORDS MANAGEMENT PLAN

1. Navy MTFs must establish local processes and procedures per SECNAVINST 5211.5D, the Manual of the Medical Department (MANMED), article 16-10, the HIPAA privacy rule, and the Health Information Privacy Regulation, DOD 6025.18-R to ensure the security and physical custody of patient medical records.

2. Medical records are the property of the U.S. Government and must be maintained by the MTF having primary cognizance for the patient's health care. The presence of clinical documentation, as represented by the patient record, is of significant medico-legal importance to the patient, the U.S. Government, health care providers, third-party payors, inspectors, surveyors, and auditors. The following topics and issues represent the minimum requirements for inclusion in an MTF's record management plan:

a. Immediate Action. Activate and use the Composite Health Care System (CHCS) Medical Records Tracking (MRT) module to track movement of outpatient records from a record storage location to a clinic, and then back to the record storage room. Guidance on setting up and activating the MRT module is available via the patient administration Web site, reference (f).

b. Prior to Patient Visit

(1) Register new patients into the CHCS database.

(2) Create a patient record for new patients.

(3) Create bar code labels for each record and scan the records into the MRT (recommended) or enter patient data manually. This establishes the initial MRT presence of the records into the record storage area.

(4) Book patient for an ambulatory clinic appointment via the CHCS scheduling module. CHCS will automatically verify the patient's eligibility for care via the Defense Eligibility Enrollment Reporting System (DEERS) prior to scheduling the appointment and generate a "pull list" for scheduled appointments.

(5) Use the pull list to locate and retrieve patient records from the storage location.

(6) "Charge-out" records for the scheduled appointment to the appropriate clinic via the MRT module, using a bar code reader and batch processing.

(7) Tailor this process to meet the specific needs of the MTF. Consider using staff member's names as record borrowers rather than generic destinations such as, clinic names.

(8) Deliver records via courier to the appropriate clinic prior to patient visits and perform "charge-ins" to the clinic/borrower via MRT.

c. Walk-ins/Same Day Appointments

(1) Outpatient records personnel will manually charge-out the record.

(2) Establish a process to retrieve or deliver records for such patients on demand. Prohibit patients from hand-carrying their own records.

d. After Patient Visit

(1) Retrieve completed records from the provider or borrower and charge them back to the record room via MRT. Consider requiring the clinical documentation, ADM coding, and return of the patient record to the record room on the same day as the patient visit.

(2) Return the records to the record room and charge them back in via MRT.

(3) Return the records to the appropriate location or shelf within the record room.

(4) Hold clinics or record borrowers accountable for timely chart completion and return of records to the record storage area with monitoring and corrective action as appropriate.

(5) Maintain positive control of the records at all times.

e. Multiple Appointments. Develop a process for transferring records between clinics for patients having multiple appointments on the same day.

f. Record not Maintained at MTF

(1) Develop a process to retain clinical documentation when the patient has an appointment but the record is not maintained at the MTF. (Network primary care manager (PCM) referral from another MTF, ship, etc.) Commands have some latitude to develop pragmatic solutions for such cases, including decisions as to whether the complete patient record is needed in the case of referrals to the MTF. Consideration should be given to the provisions of MANMED Chapter 16 (reference (c)) in regard to secondary records. It is permissible to maintain copies of clinic visit documentation, providing the other requirements of MANMED Chapter 16 are met, i.e., original documentation is filed in patient's permanent medical record with secure custody and maintenance of secondary records.

(2) Develop a process to maintain positive custody when the patient has an appointment at the MTF but the record is maintained at a branch medical or dental clinic (BMC/BDC).

g. Hand-carried Records

(1) Develop a process or procedure to retrieve records from the possession of patients who are hand-carrying them. This practice is expressly prohibited and is a primary factor in poor record availability, loss of medical-legal data, lack of continuity of care, poor command performance on compliance audits, as well as a significant legal risk.

(2) Widely publicize the change in practice since it represents a departure from a relatively common practice, inform local commanders, ombudsmen, and beneficiary groups; train patient relations staff on the appropriate handling of patient complaints; and educate staff on the change and why it is necessary.

(3) Develop and use plans to retrieve medical records from patients who resist relinquishing custody of them. Consider making a full copy available to the patient expeditiously. This will require significant support from the leadership throughout the organization to ensure medical records remain in the custody of the government.

h. Oversight. Provide resources, monitoring, and oversight of the closed record system so it can be effective and an adjunct to meeting compliance standards.

OUTPATIENT CODING PROTOCOL PLAN

1. Outpatient Coding Protocol Plan. Each MTF must develop a coding protocol plan and submit to the respective HLTHCARE SUPPO for annual review by 31 December. The purpose of the outpatient coding protocol plan is to establish guidelines for daily business practices at all levels of responsibility for documenting patient care and ensuring BUMED policies are effectively executed.

2. The MTF coding protocol plan should ensure the patient care documentation process is efficient and accurate and should include the elements defined below:

a. Policy. A general policy statement about the commitment of the organization to correctly assign and report codes.

b. Ethics. A statement clarifying that codes will not be assigned, modified, or excluded solely for the purpose of maximizing reimbursement. Clinical codes will not be changed or amended due to provider or patient requests to have particular services covered by insurance. If the initial code assignment does not reflect the actual services documented in the medical record, codes may be revised based on supporting documentation. The coding supervisor will handle disputes regarding coding with either providers or patients. The coding supervisor will determine the appropriate code to be used or action to be taken. If necessary the issue should be logged and presented for review by the Medical Record Review Committee (MRRC).

c. References or Resources. Source of the official coding guidelines used to direct code selection. (List MTF's ICD-9-CM, CPT, and HCPCS Level II Code publications; *DOD ADM Coding Guidelines*.) Resources may include additional references such as a medical dictionary, anatomy/physiology textbook, Physician's Desk Reference, etc.

d. Training and Education. MTF's initial and annual clinical coding training plan as well as the process to determine clinic specific training. The training should include acceptable documentation practices, coding practices and regulatory requirements pertaining to coding and clinical documentation, and use of standardized coding templates or superbills.

e. Responsible Personnel. Ultimate responsibility for code assignment lies with the physician provider. However, policies and procedures may indicate instances where codes may be selected or modified by other authorized individuals. Ensure these individuals are identified as follows:

(1) Personnel within the MTFs (e.g., PAD and management information departments) who ensure updates of ICD-CM and CPT code tables in CHCS and ADM.

(2) Personnel who maintain current coding and documentation references.

f. Policy and Procedures. Define procedures for the following:

(1) Guidelines for coding staff or clinical support staff to follow when the clinical documentation is not easily assigned a related code to include consultation with MTF MRA, HLTHCARE SUPPO MRA, BUMED MRA, and the NMIMC SPMS/EAS Help desk (SEAHelp Desk) at (301) 319-1296, DSN 285-1296, or by e-mail at Seahelp@us.med.navy.mil.

(2) How to obtain provider clarification of a diagnosis or procedure, as it relates to coding and procedures for late entries in the medical record.

(3) Designation of specific coding policies and procedures that apply to specialty clinics and emergency departments.

(4) Process to identify new or unusual diagnosis and procedure codes. If the code cannot be identified after consultation with the attending physician and related research, the issue should be referred to HLTHCARE SUPPO/BUMED MRAs.

Note. If the issue needs to be referred to the Unified Biostatistical Utility (UBU) Coding Committee and subsequently to American Hospital Association (AHA) for clarification and assistance, MTFs should enter a trouble ticket via NMIMC SEAHelp Desk and refer/defer to HLTHCARE SUPPO/BUMED.

(5) Process to correct inaccurate code assignments in the clinical database and the agencies and bill payers to which the codes have been reported.

(6) Process to review 100 percent of other health insurance encounters prior to submitting claims to third party payors.

(7) Process to address issues identified by claims denials to include submission of appeals if justifiable.

(8) After the discharge summary or final note is added, ambulatory procedure visit (APV) medical records are analyzed and codes selected based on complete and appropriate documentation by the provider. If the records are coded without the discharge summary or final diagnostic statements available, a process must be in place to ensure the coding is reviewed once the documentation is completed.

Note. Current coding guidelines stipulate codes are not assigned without proper provider documentation.

(9) Process to review and revise codes as necessary for previously coded records when the required documentation was incomplete or without final diagnostic statement.

(10) Process to report errors identified by logic editors or with code file and tables in an automated system. Coding staff cannot rely solely on computerized encoders. Current coding

manuals must be readily accessible and the staff must be educated appropriately to detect inappropriate logic or errors in encoding software. When errors in logic or code crosswalks are discovered, the coding supervisor must immediately report the issue to the system administrator to file a trouble ticket with NMIMC SEAHelp Desk. A copy must be sent to the respective HLTHCARE SUPPO MRA. If required, the HLTHCARE SUPPO MRA will forward the issue to the BUMED MRA for resolution.

g. Audit Plan Policy. Each MTF will have a defined audit plan for accurate coding and a consistent medical records review process. The MTF medical audit plan or policy must define the timeliness of audits, how to monitor corrective actions, as well as procedures for addressing the "Possible Concerns with Outpatient Coding Metrics" provided in reference (d).

Note. At a minimum, the MTF audit plan shall meet the requirements defined in the Data Quality Management Program.

Example. PAD head, MRA, and the coding supervisor will conduct monthly audits of medical record documentation and coding. Results of the audit, with recommended corrective actions, will be provided to the MRRC for dissemination to the appropriate department heads and clinic managers not later than (NLT) 15 working days after the audit is completed. Department heads and clinic managers must respond to the MRRC with corrective actions taken NLT 15 days after receipt of audit results and recommendations. The data quality manager will submit results and recommended actions on the commander's monthly data quality statement.

HEALTH CARE SUPPORT OFFICE
SUPERBILL DEVELOPMENT LIST

HLTHCARE SUPPO Norfolk Include subspecialties	HLTHCARE SUPPO Jacksonville Include subspecialties	HLTHCARE SUPPO San Diego Include subspecialties
Internal Medicine	Diabetic Clinic	Emergency Medicine
Allergy/Immunology	Outpatient Nutrition	Pain Management
Cardiology	Physical Medicine	Urology
Endocrinology	Otolaryngology	OB/GYN
Gastroenterology	Psychiatry	Pediatrics
Nephrology	Family Practice	Orthopedics
Hematology/Medical Oncology	Primary Care/	Ophthalmology
Critical Care/Pulmonary Medicine	Intermediate Care/Med Exams	Radiation Therapy Clinic
Rheumatology	Community Health	General Surgery
Infectious Disease	OccHealth/Optometry/ Audio	Cardio Thoracic/ Vascular Surgery
Neurosurgery	Flight Medicine	Dermatology
Plastic Surgery	Undersea Medicine	Neurology
	Physical/Occupational Therapy	

BEST PRACTICES FOR AMBULATORY CLINICS

A key requirement for providing outstanding health care services and for maintaining a consistently high level of data quality is to have standardized procedures regarding all clinical and administrative functions that take place concerning the patient encounter. Each must be accomplished with a high degree of attention to detail, ensuring thoroughness, timeliness, and accuracy. Rather than focusing on coding issues alone, it is important to design and execute a process that ensures optimization of the functions associated with a patient encounter are performed in the appropriate sequence.

1. The process begins with a patient being registered in CHCS and ascertaining if he or she has OHI. Simultaneously, patient eligibility should be verified via the DEERS to ensure authorization to receive care.

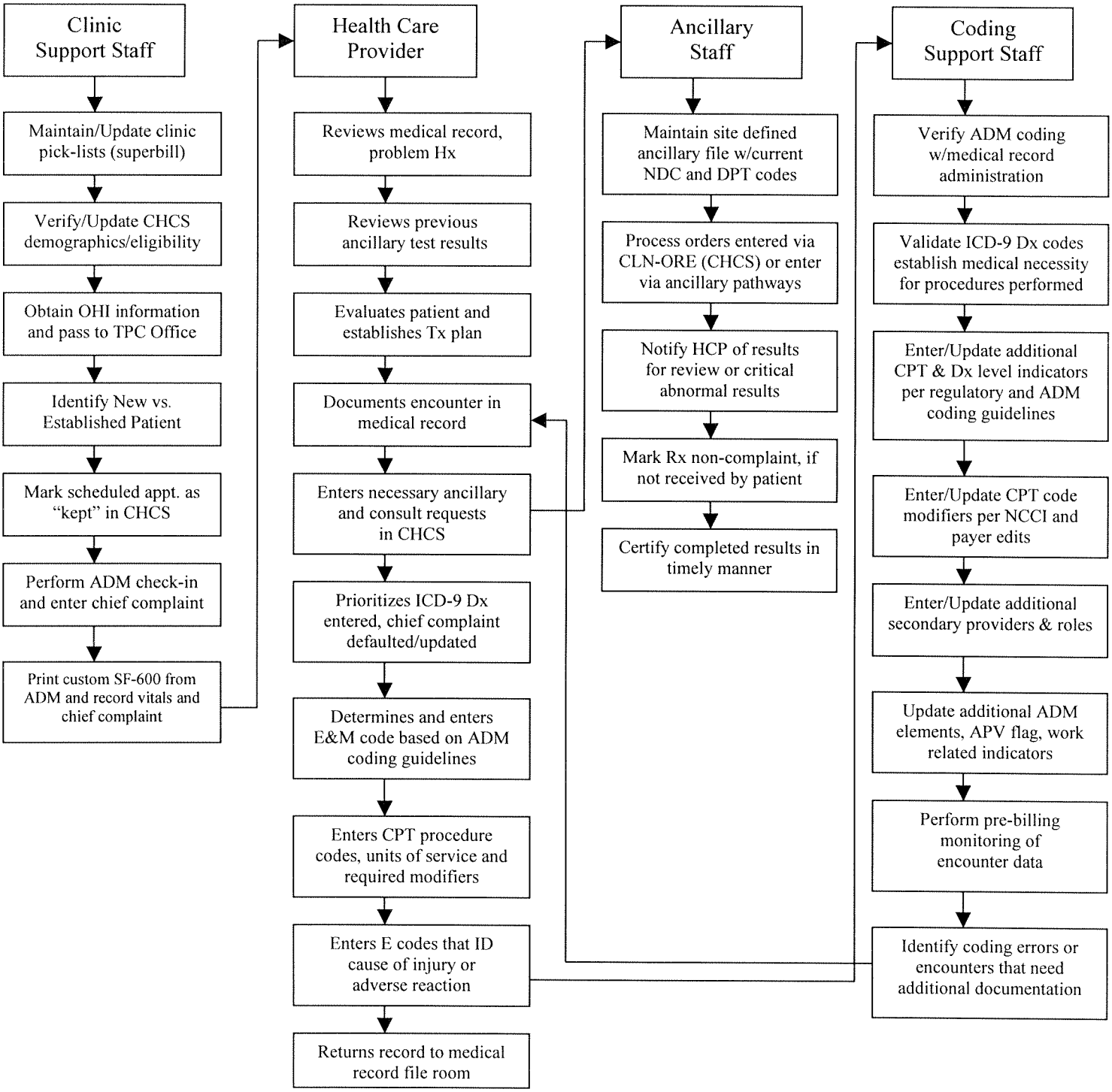
2. After registration, patient may be scheduled for an appointment. Upon check-in, appropriate entries should be made in the CHCS MRT module to indicate the record location and, if the patient is hand-carrying an outpatient medical record, it should be collected and logged into CHCS MRT by the clinic staff. If a patient does not have an outpatient medical record, one must be created and appropriate entries should be made in CHCS MRT.

3. After initial registration and check-in, a patient's demographic information, eligibility, and current health insurance coverage should be verified at every opportunity. Once a patient is at the proper clinic, clinic staff should complete the check-in, prepare necessary documents, and make all required CHCS and ADM entries.

4. Upon completion of the patient encounter, a provider and supporting staff should make all necessary entries in CHCS, ADM, and the medical record. When the medical record is complete, it should be returned to the record room. Ancillary services staff is responsible for ensuring requests for services are completed and reported in a timely manner, and that appropriate entries in CHCS are completed. Coding support staff should audit, train, and coordinate with providers on improving compliance with standards. A 100 percent review of all OHI claims is required prior to filing them with third party payors; examples are listed on the patient administration Web site, reference (f).

5. The flowchart below describes the tasks associated with this process and the usual responsible parties. There are, of course, unique differences between facilities, preventing an absolutely uniform process. MTFs must define their own processes to ensure all required tasks pertaining to an encounter are accomplished.

BEST PRACTICES FOR OUTPATIENT CLINICS



FINANCIAL REPORTING REQUIREMENTS

1. Overview. The Director for Resources Management/Comptroller has the responsibility for ensuring appropriate use and accurate reporting of Defense Health Program (DHP) resources. Resources received by claimancy 18 activities (BUMED, HLTHCARE SUPPOs, and MTFs) to support the BUMED funded outpatient coding initiative must be accounted for using the cost accounting data structure as outlined in the annual Fiscal Year Supplemental Financial and Logistics Guidance.

a. Claimancy 18 activities must collaboratively ensure that the designated cost accounting structure (as applicable) is resident in the following financial and labor reporting systems to capture costs relative to outpatient coding: Fund Administration and Standardized Document Automation (FASTDATA), Standard Accounting and Reporting System – Field Level (STARS-FL), Expense Assignment System Version IV (EAS IV), Standard Personnel Management System (SPMS), and the Defense Medical Logistics Supply (DMLS) System.

b. Obligations and expenditures incurred at the claimancy 18 activity in support of outpatient coding initiatives (e.g., contract support, travel, training) and associated man-hours and FTEs must be recorded in the applicable Operation & Maintenance (O&M) account at least monthly.

2. Cost Accounting Data Structure. The following cost accounting data structure must be used to track the BUMED funded outpatient coding initiative.

Budget Activity Group (BAG):	05 Mgmt Activities (BUMED) 03 Consolidated Health (HLTHCARE SUPPOs) 01 In-House Care (MTFs)
Program Element Code (PEC):	87798 (BUMED) 87714 (HLTHCARE SUPPOs) 87700 (MTFs CONUS) 87900 (MTFs OCONUS)
Sub Activity Group (SAG):	EP (BUMED) M1 (HLTHCARE SUPPOs) M9 (MTFs)
Sub-Functional Code (SFC):	YE - Patient Administration
Cost Account Code:	4EKB - DQ Coding Initiative
Functional Cost Code (FCC): *(Applicable to MTFs only.)*	EKA* - Outpatient Patient Administration
Job Order Number (JON):	UIC + FY + 4EKB + cost type
JON Title:	Data Quality Coding Initiative

* MEPRS Reporting sites must use the existing local 4th level code assigned.

3. Establishing JONs

a. Claimancy 18 activities must use the standard JONs as outlined in the annual Fiscal Year Supplemental Financial and Logistics Guidance. An eleven digit standard JON(s) is created as follows: The JON unit identification code (UIC), in positions 1- 5, must reflect the UIC where the BUMED funded outpatient coders and MRAs are assigned. Therefore, activities must establish JONs for their operating budget and their chargeable UICs, as applicable. The JON FY, in position 6, will be the last digit of the fiscal year. For example, "3" would designate FY 03. The standard JON serial number, in positions 7 - 11, must reflect the CAC "4EKB" plus the respective cost type. For example, "U" Contract Personnel - Non-Personal Services must be added to the JON serial number for the contract awarded. A complete list of cost types is available in section (C) of the Fiscal Year Supplemental Financial and Logistics Guidance.

b. Activities must use FASTDATA to establish the required JON(s) and supporting data elements. Once the JONs are established in FASTDATA, upload function should be performed to get the JON into STARS-FL system.

4. Recording Costs. Activities must reference the JON(s) stated above in the lines of accounting of the NC-2276 accounting document issued to Naval Medical Logistics Command (NAVMEDLOGCOM) for this initiative. The NC-2276 documents are to be initiated in FASTDATA to ensure obligations are promptly and properly recorded.

5. Recording Contract Labor Hours. Activities must update SPMS to reflect arrival of the respective coders and HLTHCARE SUPPO/BUMED MRA personnel. Activities may track contract personnel by contractor name or individual and align the organizational code where coders are assigned in SPMS. At the end of each month, the total number of hours spent in performing coder functions must be entered into SPMS and STARS-FL. Resource management personnel must obtain this information from their local contracting officer's representative/ technical liaison designated to provide oversight of the DQ medical coders contract. Activities are to use the FAA RMS data collection screen item number 4 in STARS-FL (Fastpath: TFCF) and the SPMS template to manually input the number of contract hours used monthly. Non-productive time (e.g., leave and absence) will not be tracked for contract personnel.

6. Reporting Workload. There is no additional workload reporting requirements for STARS-FL regarding this initiative. MEPRS/EAS performance measures for "EKA" remain the same. Performance metrics for this initiative will be derived from using other sources such as M2, SADRs, etc.